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Treatment of Retro-Displacement of the Uterus.

BY

CLINTON CUSHING, M. D.

SAN FRANCISCO.

Professor of Gynecology in Cooper Medical College, Fellow of the American Association of Obstetricians and Gynecologists, Fellow of the British Gynecological Society, Consulting Surgeon to the French Hospital, etc.

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Treatment of Retro-Displacement of the Uterus.

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For the purposes of this paper it is assumed that a retroflexion or a retroversion of the uterus is a pathological condition that requires treatment on account of pain, both local and reflex, or on account of disturbed function, such as dysmenorrhœa, menorrhagia, or sterility, and while it is true that in a small proportion of cases of retro-displacement in unmarried women, no untoward symptoms are manifest, the rule holds good that no woman may expect to long remain well unless her uterus is somewhere near its normal position.

As far as keeping the uterus in its normal position is concerned, and thereby relieving the disagreeable symptoms, I have successfully treated many hundred women with the various modifications of the Hodge pessary. Many of these women have been under observation for from three to six years, and at the end of from two to three years the pessary has been removed as an experiment, to determine if the uterus will retain its normal position without artificial support. Certainly not five per cent remain normal after removal of the pessary. In all cases the pelvic floor has been repaired where the woman has suffered injury to the part. The vaginal pessary then, in the treatment of retro-displacements of the uterus, must be placed in the category with wooden legs, spectacles, and ear-trumpets; mainly as an aid to render life more tolerable and comfortable, and not as a means for permanent cure.

I have done Alexander's operation several times but have not been successful with it, and it has never become popular among operators, probably for the same reason.

I have opened the abdomen and fastened the body of the uterus to the anterior abdominal wall in at least twenty cases, mostly in connection with the operation for the removal of diseased tubes and ovaries, and have been pleased with the results. How large a proportion have proved an absolute cure I am unable to say, for many of the patients came from long distances and were not again seen after their convalescence, but among those who have remained under observation the results have been satisfactory. I do not know of a case that has since borne a child, and cannot, therefore, say what effect pregnancy would have on the fixation. Opening the abdomen for the purpose of curing retroversion seems to most patients, and to most doctors, a severe and unwarrantable procedure, and surely there ought to be little wonder that this view should be taken.

While in Berlin last summer, Prof. August Martin kindly demonstrated for me an operation that is called vaginal fixation of the uterus, which strongly impressed me on account of its simplicity and because it fulfilled so completely the indications.

The woman is placed in the lithotomy position at the edge of the table, a Simons' speculum introduced, the perineum retracted and the cervix drawn down to the vulva. A strong uterine sound is introduced into the uterus and the organ held by an assistant in a position of anteversion. An incision is made with a knife directly forward in the middle line from the cervix toward the urethra for two inches, the incision extending only through the vaginal tissues. The vagina is separated from the bladder on either side of the incision for half an inch, and the bladder is then pushed off the anterior wall of the uterus up to the peritoneal reflexion. This part of the operation is much facilitated by seizing the anterior wall of the uterus with a bullet forceps, drawing it down and steadying it. The bladder is then easily pushed upward and forward out of the way, a suture of silkworm gut is now introduced through the muscular wall of the vagina on one side of the incision, an inch and a half from the cervix, then through the anterior wall

of the uterus, and out through the muscular wall of the vagina on the opposite side. The ligature is then tied and buried. A second suture is introduced in like form a half inch lower down, and the incision in the vagina closed throughout with silkworm gut.

The result is that the anterior wall of the uterus is drawn over and fastened to the anterior wall of the vagina, the bladder being pushed upward and forward.

During the past eight months I have performed this operation twelve times, and have been greatly pleased with the results. Most of the operations have been done in conjunction with the repair of the cervix and perineum. Given a case of retroversion with a laceration of the cervix and perineum, accompanied with endometritis, the following plan is pursued: The woman is kept under observation for two or three weeks before any operative procedures are undertaken. The uterus is carefully and thoroughly replaced while the woman is in the knee-elbow position, glycerine tampons are used, and this process repeated every 48 hours. As soon as it can be done safely a well-fitting Hodge pessary is introduced and the uterus kept well forward. Thus the question of the mobility of the uterus and the condition of all the pelvic organs and tissues is clearly defined.

If all goes well, at the end of three or four weeks, the patient is properly prepared by rectal and vaginal douches, and the uterus is thoroughly curetted, the cervical rents freshened, and silkworm gut sutures introduced but not shotted.

The vaginal fixation is next done, and afterwards the perforated shot, each with a small tag of black silk attached, are run up on the silkworm gut sutures in the cervix, compressed, and the sutures cut off flush with the shot. The perineum is then repaired after Tait's method, which I am firmly convinced is far the best, the silkworm gut and the perforated shot with black silk tags being again used. The next step I consider of importance, as it has much to do with the success of the plastic operations, and the ease and comfort of the patient during convalescence.

To each ounce of fresh well-made zinc ointment is added a grain each of morphine and cocaine. Two teaspoonfuls of this ointment are introduced into the vagina and thoroughly spread

over the parts with the finger. A small teaspoonful is also introduced into the rectum. By this plan the local smarting and pain are rendered tolerable, and as the ointment escapes from the vagina the new perineum is kept covered and protected from the urine, none of which can pass into the vagina. Except in cases of offensive vaginal discharge, accompanied by fever, no vaginal injections are permitted for eight days, but the external parts are frequently douched with warm carbolized water, which is followed by an application of the ointment over the new perineum. On the eighth day a vaginal injection of carbolized water is given, and now by catching up the tag of black silk thread attached to each shot, the shot and ligature are brought into view. One side of the ligature is cut, the loop removed with the least possible pain to the patient, and without disturbing the newly united surfaces. Ten days later a small Sims speculum is introduced and the stitches in the vagina and cervix are removed. In one case only has suppuration of the buried sutures occurred, but notwithstanding this, the union between the vagina and the uterus remains firm, and the uterus retains its normal position. I have thought best in all cases to have the patient wear a small Hodge retroversion pessary for the first three months after the operation, in order to assist in keeping the uterus well forward until union becomes firm at the site of the buried sutures.

Manifestly if the uterus can be kept sufficiently far forward so that the pressure of the small intestines is against the posterior wall of the organ, it will require but little force to keep it in place. If the uterus and vagina are made aseptic there should be no more danger from this operation than from any other of the plastic operations about the vagina.

Injury to the bladder would appear to be the most probable accident, but with a little care and the exercise of ordinary skill this is easily avoided. What has struck me as the most remarkable thing about the operation is that the patients do not complain of any irritation or pain about the bladder, which would naturally be expected when it is remembered that a considerable dissection is made of the tissues lying between the vagina and the bladder, and the uterus and the bladder.

It is yet too soon to decide upon the real merits of this procedure, but judging from the good results observed thus far I think we are warranted in giving it a further trial. I do believe that the operation will prove successful where the uterus is large and heavy, or where the woman has suffered enough injury to the pelvic floor to permit the pelvic contents to sag much, and I therefore strongly advise any one who contemplates this operation to first replace and keep in position the uterus for a month; then when fixation is performed to curette this organ thoroughly if advisable; to repair the cervix and pelvic floor should this be required; and to keep the uterus in a state of anteversion, by means of a pessary, for several months after the operation as a matter of safety.

Several years ago in a communication to this Society, I advocated the claims of catgut as a suture. I now only use catgut for ligature where the parts are infected by pus. In plastic surgery it is not as reliable as silkworm gut which I now invariably use for such work.

In the preparation of catgut, I have recently carried out an idea that appears to me to be of considerable practical importance. Every one who has used catgut for ligatures must have been impressed with the fact that as soon as the catgut gets wet with water or blood, it becomes slippery, and the first knot does not hold well while the second is being tied. Especially true is this when working in dark corners where the view is obstructed by blood, as in the bottom of the pelvis following an abdominal section.

I now prepare catgut in the following manner: The coils of gut are first soaked in sulphuric ether for ten days in order to render them aseptic. They are then put into a pint of pure alcohol in which has been dissolved an ounce of common rosin. By so doing I have found that the animal ligature whether wet or dry is sufficiently sticky to retain the first knot tied, without slipping, until the second is placed in position, and I know of no objection to the alcoholic solution of the rosin. This may seem a trivial matter, but I doubt not all will agree that many of our aids in surgery are in themselves trivial, but they make just the difference between failure and success.

The objection might be raised that by this operation we pro-

duce anteversion of the uterus and therefore a pathological state. I believe the so-called anteversion of the uterus is the normal position of that organ when the bladder is empty, and that the various symptoms which have been ascribed to the so-called anteversions are due to disease of the structure of the uterus, or to displacement of all the pelvic contents downward on account of injury to the pelvic floor, or to disease of the ovaries or bladder. For the last ten years, therefore, I have given up treating the so-called cases of anteversion as such, and have succeeded in giving relief in such cases by curing endometritis and subinvolution, and by repairing injuries from childbirth.

I am the more inclined to call the attention of the Society to the operation of vaginal-fixation because I have seen very little regarding it in the medical literature of the country.

Duhrssen, of Berlin, who was one of the first to perform the operation, reports 140 cases without any fatal result, and with a permanent cure of ninety per cent. His method of operating varies slightly from the one described, inasmuch as he makes the incision in front of the cervix, transversely of the vagina instead of longitudinally. The operation described is essentially that of Mackenrodt, who is assistant to Prof. Martin, and it was Mackenrodt who read the first paper on the subject.

The operation is manifestly contraindicated where the uterus from any cause is large and heavy, or where adhesions prevent its being easily placed in a state of so-called anteversion, for any dragging upon the buried sutures would certainly cause them to cut out. The operation is equally applicable to cases of retroversion or of retroflexion.